Instructions to Schools for Signing "2010 Immunization Provider Vaccine Agreement"

Pin: If you have a 4 digit PIN number from last year please write it here, if you do not have one it will be assigned to you.

Practice: This is the name of your school

Organization: School District Name

_____

Vaccine Manager: School Nurse's name and contact information _____

Phone: _____ Fax: _____ e-mail: _____

Vaccine Delivery Address:
Please fill out

_____

_____

Mailing Address:
Please fill out

_____

_____

*(**NOTE**: Please make corrections to above information and fill in blank fields)*

Please indicate any day(s) the Office is **Closed**: ___ Mon ___ Tues ___ Wed ___ Th ___ Fri

Type of Facility (please check only one box):
Please check **D** if you are a public school or check **G** if you are a private school

❒ **D**. Other Public Health - 16 (Any other public funded clinic which provides immunizations, for example Indian Health Service/Tribal Health Clinic, public school or state, district, county, city public outpatient clinic)
Please designate: _____

❒ **G**. Other Private Facility – 24 (For example, Nursing Homes, Long Term Care, Manufacturers)

Age Cohort Summary (please check only one box): Please choose 0-99+
❒ 0-18 years ❒ 19-99+ years ❒ 0-99+ years

The information contained in this agreement should be kept up to date throughout 2010. Please notify the Maine Immunization Program at 287-3746, within 10 days of a change of information, to update the contents of this agreement.

A. Vaccine Need – (Current)

For the 12-month period beginning January 1, 2010 estimate the number of patients who will receive vaccinations at your facility, by age group. Of the total number of patients, how many patients, by age group, fit into one of the categories below. Only count a patient once in each 12 month period no matter the number of visits. You may be able to get these numbers from your billing department or VFC Screening Records. These numbers do not affect your ability to receive vaccine in Maine. They do identify appropriate funding sources.

Category	Number of Patients Less than 1 year old	Number of Patients 1 through 6 Years of Age	Number of Patients 7 through 18 Years of Age	Number of Patients Over 18 Years of Age	Total
Enrolled in Medicaid					
Without Health Insurance				N/A	
American Indian or Alaskan Native				N/A	
Underinsured* (See Definition Below)				N/A	
Private Insurance					
Total		Total students in K-1	Total students in 2 and above	Total Teachers	Total population

***Underinsured Children are Defined as:**

1. A child who has commercial (private) health insurance but the coverage does not include vaccines
2. A child whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only), or
3. A child whose insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

NOTE: Children whose health insurance covers the cost of vaccinations are not eligible for VFC vaccines, even when a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan's deductible had not been met.

B. Health Professionals please list all health professionals who potentially will give vaccines. You may make changes if you need to in the future.

Please print or type the names of all health professionals authorized to prescribe and/or administer

Last Name	First Name	Medical License No. (As applicable)	Medicaid Provider No. (Physicians Only)	Title (MD, DO, NP, PA, RN, LPN, MA)

vaccines in your facility**.** If additional space is required, photocopy and attach to original.
This record is to be submitted to and will be kept on file at the State of Maine Department of Human Services, Immunization Program. **The Maine Immunization Program should be notified within ten (10) days of any changes, additions or deletions to this list.**

C. Vaccine Storage, Handling and Accountability Plan

Vaccine Storage, Handling and Accountability Plan: Practices must have a written vaccine routine and emergency storage and handling plan. This plan must address storage, handling and accountability of vaccine during emergency situations (times the office may be closed and there is a power outage) and during regular business hours. This plan will be reviewed by MIP staff during VFC site visits. You may develop your own written routine and emergency storage and handling plan or use the storage and handling plan template below. If you choose to develop your own plan, all of the following information and questions must be addressed.

Keep a copy to post on Refrigerator and/or Freezer

Practice Name: **(Required)**	**School Name**	PIN (Required) **If you have one, please list the number here**
Primary Position Responsible for vaccine and name of person currently in position: (required)	**School nurse**	Phone: (Required) **phone number**
Secondary Position Responsible for vaccine and name of person currently in position: (required)	**Name of back-up person**	Phone: (Required) **phone number**
Person with 24-hour access: (required)	**Name of person**	Phone: (Required) **Phone number**

During a Power Outage: (The following questions are to identify the steps that will be taken by your facility personnel to ensure temperatures of the vaccine will be maintained appropriately at all times. This includes periods of time when power outages occur, both when the facility is open and closed.)

1. ☐ **This Facility has a back-up Generator. (Go to Question 2)**

   If you do not have a generator, please do not check the above space and your district public health nurse (PHN) will help you in the events of power outage. Contact information for district PHN will be available later.

   The **location, contact name and phone #** of an alternative location to store vaccines during a power outage is **REQUIRED** if Facility does not have a back-up Generator

   #1.Location please list _____ Contact Name please list _____Ph# phone number

   #2.Location please list _____ Contact Name please list _____ Ph# phone number

2. How will you be notified when a power outage occurs at your facility when your practice is closed? (Required)
   Please list how you will be notified if you have a power failure at your school.

Skip Questions 3-5.

6. **Who is responsible for training new staff on the Storage and Handling Policy and Procedures for this facility at this site?** Please fill in **"the summer institute"**

For the Items 7 through 11, please read through each list of requirements and write in the space below each item with "I have read and agree to follow the requirements".

7. **Describe your procedure for monitoring refrigerator/freezer temperatures twice daily – including the name of the responsible position if not the primary position listed above. Include steps to be taken if temperatures are out of recommended range.**

Procedure should include, at a minimum:

1. Name of responsible person (if not the primary position listed)
2. Checking temperatures for each storage unit at least twice a day (morning and evening) and recording those temperatures on temperature log
3. Adjusting the thermostat of the storage unit(s), when necessary, to bring temperature back in range. Note: When adjusting the thermostat does not bring temperatures back in range, it is recommended to move vaccine to a stable environment until temperatures in the storage unit can be maintained at appropriate levels.
4. When the temperatures were outside the recommended range, provider must document all action taken, including but not limited to moving the vaccine to another location until temperatures in storage unit can be stabilized. This can be done on the back of the temperature log or on a separate page attached to the log with the date that the temperature was out of range. IMMPACT2 users can provide documentation of actions taken using the Comments text box on the temperature log screen. Notify MIP when vaccine has been involved in a cold chain failure
5. If temperatures are outside appropriate range, practice will contact Vaccine Manufacturer for guidance on viability of vaccine(s) and fill out vaccine wastage worksheet **(Attachment B)**

Fill the space with **"I have read and agree to follow the requirements,"** if you will follow**.**

8. **Describe your procedure to ensure vaccines are immediately unpacked and stored at recommended temperatures upon receiving shipment. Include maintenance of the cold-chain prior to vaccine administration. Include responsible position if different than the primary position named above.**

1) Procedure should include, at a minimum:

a) When vaccines arrive at practice, immediately notify appropriate staff (identify who this is and all backup personnel for times primary is unavailable)
b) The vaccines will immediately be unpacked and cold chain monitor checked for activation. MIP will be notified if cold chain monitor was activated
c) The vaccines will be checked against the packing list for matching names/lot numbers
d) Vaccines will immediately be placed in appropriate unit (fridge and/or freezer)
e) Practice will not pre-draw vaccines
f) Temperatures will be checked and recorded at least twice a day

Fill the space with **"I have read and agree to follow the requirements,"** if you will follow**.**

9. **Identify steps taken to advise maintenance and/or cleaning personnel not to unplug storage units (e.g., safety outlet covers and *Do Not Unplug* stickers are placed on the unit or near the outlet and circuit breakers.** *(These stickers are available at no cost from the Maine Immunization Program.)*

    Steps should include, at a minimum:
    a. Do Not Unplug signs or stickers placed on each unit (or near relevant outlets)
    b. Do Not Unplug signs or stickers placed near relevant circuit breakers

    Fill the space with **"I have read and agree to follow the requirements,"** if you will follow**.**

10. **Describe your plan for ordering vaccines, controlling inventory and ensuring required accountability paperwork is submitted monthly. Include the name of the responsible position if different than primary position named above.**

    Plan should include, at a minimum:

    1. Order vaccine in accordance with actual vaccine need; avoid stockpiling or build-up of more than six week supply
    2. Submit monthly temperature logs when MIP supplied vaccine is stored
    3. Submit monthly usage reports when MIP supplied vaccine is in inventory.

    Fill the space with **"I have read and agree to follow the requirements,"** if you will follow**.**

11. **Describe your plan for minimizing vaccine wastage (e.g. check and rotate stock to assure shortest dated vaccine is used first; transferring short dated vaccine to another Maine Immunization Program participating provider, etc.) Include responsible position if different than primary position named above.**

    Plan should include, at a minimum:

    1. Short-dated vaccines are stored in the front of unit and used first (stock rotated)
    2. Vaccines are not stored in the door of storage units
    3. Vaccines are properly placed in storage units with air space between the stacks and
    4. side/back of the unit to allow cold air to circulate around the vaccine.
    5. Transfer short dated vaccine to another MIP participating Provider
    6. Practice will not pre-draw vaccines.

    Fill the space with **"I have read and agree to follow the requirements,"** if you will follow**.**

The information supplied in this Storage and Handling Plan may be verified by the State during a visit and/or in the event of a cold chain incident.

_____ _____

Vaccine Manager Prescribing Physician or Equivalent

Reminder: A copy of the Storage and Handling Plan must be submitted with the Provider Agreement. Keep a copy of this Plan in a location easily accessible by all staff and on your storage units.
Please read the attached documents and print them out for reference for the future use.

D. Agreement Signature Page

NOTE: Individuals or entities that have been placed in non-payment status under Medicare, Medicaid and other Federal health care programs, including the VFC program by the U.S. Department of Health and Human Services, Office of Inspector General (OIG) or through Executive Order by another Executive department (e.g., Department of Transportation, Office of Personnel Management, Department of Justice, Department of Labor, Department of Defense) are not allowed to enroll or participate (applies to Section B) in the VFC program receiving VFC vaccine for VFC-eligible children.

This entire agreement must be faxed to 287-8127. Please make sure all sections are signed.

By signing this Provider Vaccine Agreement you agree to implement and will ensure that all staff, at the facility listed on Page 1, adhere to the requirements of the VFC Program listed in Attachment A (Please read online).

☐ I do not want to have address and telephone information for this facility shared with other providers or public health entities in the State.

_____ PIN #:_____
Date

_____ _____
Typed Name – School Nurse Typed Name –Prescribing Physician Or Equivalent

_____ _____
Signature – School Nurse Signature – Prescribing Physician Or Equivalent

Please return completed pages 1 -10 and fax to 287-8127.

Keep a copy of the agreement on file at your facility.

Questions? Call 1-800-867-4775 or (207) 287-3746

For Office Use Only:

Date Received:_____ Data Entry Initial_____ Reviewer Initial_____ Date Completed_____